TRAUMA MATTERS

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Reflections on the Impact of the Sandy Hook School Shootings on How We Think About Children's Mental Health in CT

Last year, 2013, was New Haven, Connecticut's Clifford Beer's Clinic centennial anniversary. One hundred years ago it was one of the first stand-alone mental health clinics in the nation. "Trauma matters" to us at Clifford Beers. Traumatic stress has been the center of our work since our beginning. Our founder, Clifford Beers, a psychiatric patient, believed that there should be a place in the community where folks suffering with mental illness could receive services so as not be removed from their families for years to live in asylums. Beers was in Connecticut Valley Hospital for three years after he lost a brother to epilepsy, which precipitated his decline into depression and his attempted suicide. Family stressors and traumatic events are wrapped into our founding history.

Let us fast forward through the hundred years of our Clinic's work in the community and focus on our response to the school shootings in Sandy Hook. The Clifford Beers Emergency Psychiatric Team was called on 12/14/2012 to join the Family Notification Teams along with the state police. Since then, we have played an active role in the recovery efforts in the new Sandy Hook School. We are learning a lot about creating environments that support recovery, and we see how important it is to have the whole community openly talk about trauma and mental health. We are hopeful that efforts in Newtown will assist our work in New Haven, with its own experiences of community violence, to help create resilient environments within the school communities.

One of the political effects of the Sandy Hook shooting has been increased attention on mental health services, particularly for services for children, youth, and families. In early 2013, I was appointed to the Governor's Commission on Sandy Hook, where we heard many testimonies related to the stigma of mental illness, how children are languishing in hospital emergency departments waiting to access care, and the lack of services for the commercially insured families across the state. We heard from affected parents about how difficult it is to live with a child, particularly a young adult, who has untreated mental health issues. Additional testimony focused on the lifelong physical and mental health impact of adversity and trauma. From this testimony we learned that Connecticut, although rich in resources comparable to other states, has definite gaps in service. It seems that one of the problems in the current service delivery model is how our mental health services are delivered according to age; adults' services are separate from children's services. It is very clear that children's mental

health issues are often related to what they are experiencing in their environment. The adults in the family can also require support and services; however, unless the adults have a severe and persistent mental illness, there are few clinics in Connecticut where a parent and child can access services in the same place.

At Clifford Beers Clinic we have decided that we need to increase our capacity to treat members of the whole family when needed; sending the adults to another clinic is impractical and ill-advised. For example, we find that many children who have experienced sexual abuse have parents who have had the same thing happen to them, but never had treatment for their abuse. To treat victims of sexual abuse, one of the primary evidenced-based treatments is trauma focused cognitive behavioral therapy (TF-CBT), which requires parent or guardian participation. If the adult is triggered by listening to his or her child's trauma narrative, we cannot provide the therapy the parent may need, and there is very little we can offer him or her for services. As part of our centennial strategic plan, we are working to create programs that offer services for the whole family, regardless of age.

Although trauma-informed care has grown throughout the state, and many agencies are providing trauma screening and mental health services, in particular TF-CBT, we still have a long way to go in creating a trauma-informed network of children's mental health services in Connecticut. If children's services are to be trauma focused, we must not rely only on mental health providers, but also gain the participation of pediatricians, schools, and after school programs. We must work to create a strong community that focuses on healing from adversity. We must strive to decrease the adversity and stress family's experience, while keeping in mind how basic necessities like food, shelter, and safety are key ingredients to being trauma focused. Over the last several years evidence has been accumulating that shows early exposure to toxic stress significantly increases children's risk of mental health disorders.

The social and financial cost of ignoring childhood trauma is enormous. Fortunately, the course can be corrected, and a child who is exposed to Adverse Childhood Experiences (ACES) and who receives treatment may not only heal but indeed thrive. To that end, the City of New Haven, led by Clifford Beers Clinic, will implement a collective impact initiative called the "New Haven Trauma Coalition," which will be a trauma-informed collaborative system of care that involves the entire Greater New Haven community to treat ACES. We will do this by creating a citywide coalition that will focus on current-child-serving systems to help them become a network of care that will assist children and families to live healthy productive lives, free from trauma and debilitating levels of stress.

From the tragedy in Sandy Hook we hope to learn how to build strong communities that are knowledgeable and focused on recovery. We know from our experiences in Newtown, that it does take the whole community working together to recover. Clifford Beers, as an agency and partner in New Haven, wishes to help families to be stronger and safer through building a community that is trauma-informed.

Submitted by Alice Forrester, PhD,
Executive Director Clifford Beers Clinic

Attuning to Attachment-Based Deficits

To understand the whole person during the intake process or clinical treatment, it can be helpful for the therapist to understand the individual's early attachment, especially for clients presenting with affective instability, powerlessness, shame, and low self-esteem. This article aims to assist in the trauma treatment process when there are impasses in the work—when unforeseen blocks occur or when progress is lacking in the trauma treatment.

Attachment is defined as the dyadic regulation of emotion. According to Shore (2000), the early social-emotional environment mediated by the primary caregivers directly influences the final hardwiring of the brain circuits that are responsible for future social-emotional development. This results in both the mother and child recreating a psychophysiological state similar to the other. This nonverbal, emotional attunement between infant and caregiver

shapes the development of the baby's stress-coping system. A secure, healthy attachment facilitated by emotional attunement is critical to the development of affect regulation. When attachment problems occur, the growing person's capacity for affect tolerance and regulation is compromised. People with insecure attachments are also more vulnerable to having low self-esteem and body-image issues (Schlolom, 2009). Mary Ainsworth's (1970) theory of attachment described three categories of attachment: (a) secure attachment, (b) ambivalent-insecure attachment, and (c) avoidant-insecure attachment. Mary Main and Judith Solomon (1986) later added the category of disorganized-insecure attachment.

The following is an overview of the attachment categories:

- Secure: Children's needs are met with appropriate sensitivity, good regulation, and closeness. As adults, they can form trusting relationships and generally have good self-esteem.

- Ambivalent-Insecure: Children are characterized by excessive involvement, inappropriate dependency, overwhelming and overanxious demeanor. As adults, they may show high levels of distress and ambivalence toward others.

- Avoidant-Insecure: Children's relationships are marked by a lack of mutuality, rejection, and a lack of closeness with the caregiver. As adults, they may have problems sharing intimate feelings or investing themselves socially or romantically.

- Disorganized-Insecure: Children's memories are chaotic, confusing, and frightening. As adults, they may have difficulty with closeness, have high distress, and may be indicative of psychopathology.

In clinical work, focusing on attachment issues often takes secondary priority to seeking the "big T" traumas. Clinical red flags, such as physical or sexual abuse, are acts of commission, whereas those who have undergone upbringings of chronic neglect suffer from acts of omission. Those who suffer from acts of omission in early childhood may have had caregivers who were absent or not able to be fully present physically or emotionally. Because they are omissions, individuals often do not recognize these factors as major influences on their development. Lacking external responsiveness from caregivers causes children to lose their ability to regulate their own emotions as it is harder to know what is acceptable and appropriate. Attention should be paid during the intake process as to what was happening in their families during their early childhood years. Were the caregivers absent, in crisis, dealing with addiction or illness, overtaxed, suffering from separation or isolation from sources of support, or unprepared for parenting?

Asking about the client's parental history around conception, the pregnancy history, and the first few years of life, when brain development is greatly accelerated, can be essential. Knowing the history of early relationships will shed light on the level of the self-reflective capacity of cohesive narration. Looking for a coherent narrative versus one that is vague with inconsistencies is key. Much of what occurs between birth and the third year is nonverbal and can be overlooked from the narrative of the intake. What may be left is either a narrative told to the client or the felt-sense of the environment at the time. Neuronal wiring that is set into place during these formative periods of brain development has long-term and widespread impact. Consider the following case: a young man sought help through Eye Movement Desensitization Reprocessing (EMDR) therapy for unstable relationships in which he would both push away and become highly dependent on his partner. He had frequent, destabilizing verbal and physical outbursts. It was discovered during his treatment that his parents had left him in the care of an emotionally abusive relative during his toddler years. When the focus was on his core belief of "I am unworthy of love," and the trauma of this severed attachment was cleared, he was able to more effectively work on skill building regarding emotional regulation and appropriate connectedness in his relationships.

During the intake process in trauma work, an opportunity to embark on a dual mission exists: create a safe space where early history can reveal itself and form a reparative relationship, one of attunement and security, a place where the self can develop safely. Learning about different attachment styles can enhance the trauma therapist's understanding of a client and hopefully contribute to the efficacy of the therapy.

Submitted by Cheryl Kenn, LCSW

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Trauma and Incarceration: An Opportunity for Treatment and Recovery?

This article is the first in a series examining trauma and trauma-related experiences among incarcerated individuals, a sometimes overlooked population when it comes to assessing and treating trauma either upon initial contact with the prison system or post-release. The series will primarily focus on trauma in men within the prison system. Nationwide men comprise 91.3% of incarcerated individuals.

The incarceration rate of the United States is currently the highest in the world … by far! At the end of 2010, the International Centre for Prison Studies (ICPS) estimated the rate in the United States to be 730 per 100,000 adults. The ICPS placed Russia second at 577 per 100,000.

In contrast Canada's rate was 117 per 100,000 (ranked 123 in the world) and China's rate was 120 per 100,000. Among other developed English-speaking countries, England and Wales have a rate of 154 per 100,000 (as of 2008) and Australia 133 per 100,000 (as of 2010).

Among other developed countries Spain's rate is 159 per 100,000 (as of 2011); Greece's rate is 102 per 100,000 and Japan's rate is 59 per 100,000 (as of 2009). Comparing the U.S. rate to countries with similar percentages of immigrants, Germany has a rate of 85 per 100,000 (as of 2009); Italy has a rate of 113 per 100,000 (as of 2010) and Saudi Arabia has a rate of 178 per 100,000 (as of 2009). And finally comparing countries with a zero tolerance policy for illegal drugs, Russia's rate is 577 per 100,000; Kazakhstan's is 400 per 100,000; Singapore's is 273 per 100,000; Sweden's is 78 per 100,000 and Japan's is 59 per 100,000.

Given the United States leads the world in incarceration rates it behooves us to take a closer look at the complex interaction of trauma histories and events, mental illness, substance abuse, and prison-related re-traumatization of individuals residing in U.S. prisons. Incidence of trauma histories and events among incarcerated individuals is significantly higher than that of the general population. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 95% of women and 89% of men entering jail diversion programs have experienced physical or sexual abuse, and studies indicate higher rates of traumatic experiences and symptoms of trauma among prison populations who are also coping with mental illness and substance abuse.

The following questions thus become highly relevant:

- What is the prevalence of early and/or prior trauma experiences among incarcerated populations? To what extent is childhood trauma a predictor of substance abuse, violence and subsequent incarceration?
- How does the presence of mental illness interact with vulnerability to trauma and subsequent incarceration?
- Does trauma-informed correctional care exist? Is trauma-informed correctional care even possible given potentially conflicting goals of prisons: confinement and control vs. rehabilitation? If trauma-informed correctional care does exist, does it exist for both men and women and has it been shown to be "effective?" What are the effects?
- Are trauma assessments performed on individuals entering and/or exiting the prison system and, if so, which assessments are most useful?
- Is trauma treatment feasible for individuals while incarcerated and/or at post-release? Do specialized evidence based trauma treatment models exist for imprisoned populations and are they gender specific?
- Does treatment for traumatizing events among incarcerated individuals result in lessened violence and enhance recovery from substance use and mental illness and in turn contribute to a lowered risk for future incarceration?
- How widespread is trauma treatment in prisons and is it an integral part of treatment for substance use and mental illness – both nationwide and in Connecticut?
- What barriers exist that prevent imprisoned men from seeking and benefiting from trauma treatment if it is available?

Some or many of these questions may have no clear or easy answers. Nevertheless it is interesting to speculate on the potential positive effects of reducing early childhood trauma experiences and providing both a trauma-informed prison environment and trauma treatment during and after incarceration.

In closing, here are some incarceration statistics for Connecticut. According to the U.S. Department of Justice figures for 2008, Connecticut ranked first in the Northeast in terms of its incarceration rate of 407 per 100,000 residents. The data are based only on sentenced prisoners under the jurisdiction of state and federal correctional authorities and do not include prisoners in local jails. Although Connecticut ranked 25th among all states (1 ranking = highest incarceration rate), its rate of incarceration exceeded Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, New York, New Jersey and Pennsylvania. The incarceration rate for all "northeastern" states is 306 per 100,000.

As of January 1st, 2014, Connecticut state prison facilities housed 16,594 individuals; 15,484 (93.3%) were male and 1,109 (6.6%) were female; these figures include both accused and sentenced individuals under the jurisdiction of the State of Connecticut.

Clearly for both Connecticut and the nation, the numbers emphasize the need for discussion of trauma among incarcerated populations to be focused on the male experience while including and perhaps learning as well, from the female experience.

Submitted by Steve Bistran, M.A.

For a complete list of references for this article please visit: http://www.womensconsortium.org/References_Trauma_Matters.cfm.

Preparing for Stress

Stress has been linked to negative health factors that range from depression and cardiovascular disease to human immunodeficiency virus. Despite numerous studies that document this link, we have perhaps placed too much blame on stress for poor health. What if believing stress is harmful is actually harmful? By understanding how our own perception can be more damaging than our level of stress, we gain insight into the nature of stress, trauma, resilience, and our health.

In June 2013, Dr. Kelly McGonigal, a health psychologist and lecturer at Stanford University, delivered a presentation at a TED Conference, a global conference where the world's foremost speakers present innovative ideas. She explained that instead of focusing on reducing stress we should focus on our beliefs about stress. In a study of 29,000 adults conducted by researchers at the University of Wisconsin, participants were asked to rate their level of stress and how much they believed stress impacted their health. Their answers were then compared to public death records for eight years. The results showed that stress increased an individual's risk of dying by 43%, but this was only true when an individual believed that stress was harmful to his or her health. In fact, individuals who did not view stress as harmful had the lowest risk of death, including those who had high levels of stress (Keller, Litzelman, Wisk, et al 2012).

In many ways, the study McGonagall described, represents the mind-body connection. The placebo effect is a good example, in which patients who have been given an ineffective therapy see real improvement simply because they believe that it will be successful. In a study done at Harvard, participants in the experimental group were primed to interpret stress as helpful and were then put into stressful situations. Though all individuals' hearts were pounding, those who believed their body's reactions were helpful had open blood vessels in their heart. Open vessels in the heart are healthier for the body and are seen when someone experiences joy or courage. Those experiencing a typical negative stress response had constricted blood vessels (Jamieson, Nock, Mendes, 2012).

This positive reaction to stress may come from oxytocin, known as the happiness hormone. Its role as a stress hormone is often overlooked. Oxytocin is released during stress and makes us more social, primes us for empathy, and makes us more willing to help others. When our bodies are flooded with the hormone we want to talk with others. By conversing, we release even more oxytocin. The heart has receptors for oxytocin that help heart cells regenerate and heal. In other words, socializing can help repair your heart.

McGonigal's recommendation is to rethink the role and effects of stress to instill resilience. Perceiving your heart's pounding as something that energizes you will help your body prepare for new challenges. Believe that rapid breathing is a helpful way to supply more oxygen to your brain. In effect, think of your reaction to stress as a way to prepare for the coming situation.

McGonigal gives us a different way to think about stress and coping strategies. What we can take away from this are valuable ideas about resilience and trauma. Teaching these individuals about responses they should feel during stress, as well as how some help prepare the body, could help instill a more positive response to stress. Think about this in relation to the role of those treating trauma. If we do not have the power to reduce traumatic events, could focusing on instilling these beliefs about the body, and giving social support help minimize some of the negative effects of trauma or at the very least improve cardiovascular health.

In some ways, perhaps we are already on the right track. Many of the models used to address trauma encourage those who participate to talk about their lives in a group setting. This is similar to the idea that oxytocin increases when, under stress, we socialize to better prepare our heart and our body for upcoming situations. What we can be sure of is that our mind's effect on the body is powerful, and that by improving our perspective on stress, we may be better equipped to handle it.

Submitted by Olivia Yetter, B.A.

For a complete list of references for this article please visit: http://www.womensconsortium.org/References_Trauma_Matters.cfm.

Professional Self-Care

During a recent workshop I facilitated, I made an unrelated comment about professional self-care. After the workshop, a participant spoke to me and asked me what I meant. We spoke for a while, and he took some notes. I have been thinking about this since and realized that personal self-care does not get much attention and that helping-professions and professional self-care receives even less.

Drawing on the work of Saakvitne and Pearlman (1996), I developed some self-assessment questions related to professional self-care activities. **Reflecting on your answers may indicate what you need to add to or subtract from your professional life:**

- Do you build in time during the day to take a break, eat lunch, or take a few breaths?
- Do you leave the agency a few times per year to attend professional workshops or conferences?
- How would you describe your level of professional connection with colleagues and co-workers?
- Is supervision a nurturing, growth-promoting experience?
  - Does your supervisor understand trauma theory, symptoms, and vicarious trauma?
  - If not, do you have an internal or external peer supervision group?
- Are you supported in using evidence-based treatment approaches in the way the models were developed and tested?

These questions are not necessarily easy ones with comfortable answers; however, they lead us in the direction of protecting ourselves from professional harm (compassion fatigue, vicarious trauma, etc.) and protecting our clients from the harm caused by exhausted and depleted providers.

Submitted by Eileen M. Russo, M.A., LADC

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The Connecticut Women's Consortium
2321 Whitney Avenue, Suite 401
Hamden, CT, 06518

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